Information asymmetry in process consultation

An empirical research on leader-client/consultant relationship in healthcare organizations

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Received 29 March 2013
Revised 25 July 2013
15 November 2013
Accepted 17 November 2013

Abstract

Purpose – The purpose of this paper is to revisit Schein's proposed process-consultation approach as a general framework for management consulting in the light of some premises of the agency theory, namely the behavior induced by the asymmetry of information between the principal (leader-client) and the agent (consultant).

Design/methodology/approach – Empirical research consisted of an in-depth, qualitative and phenomenological analysis of 13 cases of organizational intervention based on the practice of four senior consultants in a Canadian management consulting firm whose philosophy is based on organizational development principles and practices. All the cases chosen are characterized by a situation of strategic change as a result of governmental reforms in the healthcare sector between 2005 and 2008.

Findings – Overall, the study shows that the relationship between leaders-clients and consultants varies from one stage to another throughout the consultation process and that the information asymmetry does not always benefit the agent as stated in the agency theory. The consultants are required to play diverse roles, either in combination or alternation, during the consultation process; the facilitator's role, stated as the more efficient role in Schein's perspective and the more altruistic from the point of view of the agency theory, is not necessarily the role preferred by managers. Moreover, results highlight the idiosyncrasies of healthcare organizations, namely the phenomenon of escalating indecision that comes into play during the implementation phase of change, worth taking into account in the practice and theories of management consulting.

Practical implications – This analysis raises a number of questions about the general understanding and applicability of the process consultation as defined by Schein. Perhaps the four consultants have not perfectly mastered the interpersonal skills that Schein's model presupposes. One may also conclude that the model does not always respond to the expectations and needs of leaders and managers and that, for many consultants, it is difficult to adopt only one role model throughout the consulting process. One may also question its realism in a context of interventions in public organizations, with a plurality of interest groups and ambiguity of goals, where governmental reforms are pressuring managers to control costs.

Originality/value – According to Eisenhardt (1989) and Hendry (2002), the agency theory offers promising avenues if combined with other theoretical anchors such as the field of organizational behavior. This study scrutinizes the leader-consultant relationship, and more specifically the type of assistance requested by healthcare leaders as they experienced strategic change and how consultants responded to these requests.

Keywords Agency theory, Consultants' roles, Healthcare organizations, Process consultation, Experiential approach

Paper type Research paper

The author(s) wish to thank the Social Sciences and Humanities Council (SSRH) of Canada for the financial support in the production of this paper.

Leadership & Organization Development Journal
Vol. 36 No. 2, 2015
pp. 177-211

0143-7739
DOI 10.1108/LODJ-03-2013-0037

Introduction

The leader-client/consultant relationship has been the focus of many studies in the literature on management consulting (Barctecko, 2010; Davenport and Early, 2010; Fincham, 1999; Nikolova and Devinney, 2009; Ulvila, 2000; Werr and Styhre, 2003) and has been portrayed in many ways (Mohe and Seidl, 2011): as a community of interpretive communities (Devinney and Nikolova, 2004), as business partners (Biswas and Twitchell, 2002), as a cooperative endeavor based on trust (Furusten and Werr, 2005), as a social fabric embedded in an enterprise (Kitay and Wright, 2004) or as an area of potential tensions and paradoxes (Shapiro *et al.*, 1993; Verstraeten, 2007; Whittle, 2006). Thus, another prevailing model of the leader-client/consultant relationship is based on a certain number of assumptions originating primarily from the field of organizational development (OD) and more specifically the work of Schein, whose postulates have been challenged by many authors (Glücker and Ambrüster, 2003; Nikolova and Devinney, 2009; Sturdy, 1997, 2011) but rarely been tested or validated empirically. According to Verstraeten (2007, p. 20), the field of OD is part of this academic tradition known as the "human relations school" initiated in particular by Kurt Lewin in the forties and enriched by the contributions of Lippitt and Lippitt, Argyris and Schön. Although the entire field of OD is not limited to organizational consultation, its proponents favored an action-research strategy and put forward an integrated system of methodological proposals and positioning for the consultant (see e.g.French and Bell, 1999; Brown, 2011); among the different models of intervention put forward in the OD field, the process consultation' model of Schein is considered quite central and has been a current reference for management consulting in the field of OD (Mohe and Seidl, 2011). As a result, substantial amounts of highly normative, humanist-inspired literature have been amassed on the specifics of, and steps to follow in, management consulting in organizations.

This paper examines the concept of the leader-client/consultant relationship at the core of the management consulting model proposed by Schein, highlighting the main limitations of the model raised by authors in the field and revisiting them in the light of some premises of the agency theory. Yet, despite the interest in this subject, few recent studies have addressed the behavior induced by the contractual nature underlying this professional relationship. Although very much present in literature related to classical economic theory (Hatch, 2012), the agency theory was developed, for the most part, by Jensen and Meckling in 1976. The latter stressed the importance of the contractual relationship between a principal (generally a corporate manager) and an agent (person who performs the tasks) and the dilemmas that can arise, particularly for the principal. Indeed, despite the contract that binds them – which should normally minimize the asymmetrical nature of the relationship – the agency theory highlights the potential risks of dysfunction particularly: the divergence of goals between the principal and the agent (with each seeking to maximize personal interests) and the presumed expediency of the agent *ex ante* (the agent is better versed than the principal in how to accomplish the tasks and will attempt to influence the terms of the contract in his favor – adverse selection situation) or *ex post* (once in the company, the agent will only filter information to his advantage to the principal – moral hazard situation). Since its dissemination, the agency theory has been reviewed and appraised repeatedly by several authors including Eisenhardt (1989), Hendry (2002) and Wright *et al.* (2001). According to the latter, several premises underlying this theory warrant further investigation (divergence of goals and expediency of the agent), particularly in organizational contexts that rely on professionals (Sharma, 1997) and where the principal/agent relationship cannot be viewed as a simple dyad, but rather as a convergence point for a network of stakeholders (Mukherji *et al.*, 2007;

Nikolova and Devinney, 2009). This study addresses these two unique requirements. The results of empirical research conducted with a management consulting firm working primarily with healthcare sector managers will be presented and serve to highlight specificities that warrant consideration within the framework of the principal (which in this research will be designed as the leader-client) and agent (which in this research will be designed as the consultant) relationship in this specific sector. The paper is structured as follows: the first section describes the context of the research and explains the choice of the healthcare sector in this research; the second section presents the two main constituents of our theoretical framework, namely the management consulting model advocated by Schein followed by a summary of the main postulates underlying the agency theory. As these two constituents are reviewed, they will be weighed against different scenarios of principal-agent models proposed by Waterman and Meier (1998); the third section presents the methodology framework; the fourth section presents the results; the conclusion highlights the main contributions of the research.

Context of the research

In the context of this research, the healthcare sector was targeted as our field of investigation primarily for the following reasons:

- the many reforms associated with this sector, owing to growing concern over rapid public expenditure increases and an organization viewed as deficient in organizing healthcare;
- pressures on healthcare establishment managers to implement the various reforms and make requisite changes;
- the pluralistic nature of this organizational context, which imposes upon managers a form of governance focussing on negotiation, persuasion and the cooperation of different stakeholders involved in organizational change; and
- observation of the significant expansion of the management consulting business in this sector to support efforts at change introduced by managers.

It is important to note that the structure of the healthcare system in Canada is determined by the Canadian Constitution, wherein roles and responsibilities are shared between the federal government and the 10 provincial governments, including Quebec (main location of this research). It is important to mention that Canada is a federation of ten provinces, and that certain matters, namely health and education, fall under the provincial jurisdiction. The role of the federal government consists essentially of defining and ensuring the application of national principles under the terms of the *Canada Health Act* (Health Canada, 2011). The Act lays out the main criteria and conditions of the healthcare plans that the provinces must meet in order to receive full federal cash transfers in support of health. The provincial governments, on the other hand, manage and provide most healthcare services, oversee the planning, evaluation and financing of healthcare services, and negotiate fees for professionals and employees with the representatives of relevant associations and trade unions. Healthcare is a public service[1] financed from general revenue raised through taxation at the two main levels of government (federal and provincial). However, the proportion of expenditures earmarked for the healthcare system expressed as a percentage of the gross domestic product has increased from 7 to 11.7 percent from 1975 to 2010. At least four major issues guide a set of government reforms in this sector (Health Canada, 2011; Forget, 2002;

Livingston, 1998): the aging population, developments in medical technologies and the pharmaceutical industry, and the level of public debt along with the importance of maintaining a balance between the different missions of the State. In addition to these concerns related to increased expenditures, there are coordination problems between different government authorities and establishments, and between groups of professionals, leading to adverse impacts on the continuity and accessibility of services (Pineault *et al.*, 1993).

These concerns have led various provinces, including Quebec, to make relatively important legislative amendments to ensure a better functioning of the general organization of the social and healthcare system. Thus, the Quebec Act of Health Services and Social Services adopted in 2004 substantially reduced the number of service providers by proceeding with organizational mergers and revising the mission of these same establishments. This new legislation also entrusted a greater role to regional levels in the coordination of services. Problems encountered during the implementation of all these changes have been highlighted by several researchers in Canada and Quebec (Denis *et al.*, 2009; Gilbert *et al.*, 2007; Forget, 2002; Palley and Forest, 2004).

Given the intensity of organizational change experienced by managers in this sector in recent years, they have increasingly turned to management consultants to help them navigate change. Thus, in a study conducted by Canadian Association of Management Consultants (CAMC, 2005), management consulting services in the healthcare sector have grown rapidly (CAMC, 2005). Likewise, a number of researchers (Gilbert *et al.*, 2007; Glassman and Winograd, 2004; Lalonde, 2014; Lapsley and Oldfield, 2001; St-Martin, 1998) have drawn attention to the unique nature (pluralistic environment, public management of funds, regulations governing professional responsibilities, etc.) of this sector and its impact on the consultation model sought by managers having to implement change resulting from governmental reforms. Thus, while noting the prevalence of several models of practice in the literature on consultation, the model of OD stands out quite clearly, particularly when the situation involves the management of organizational change in a context centered on negotiation, persuasion and cooperation, as is the case in the healthcare sector. However, a review of the literature in the field of consultation offers few insights into consultants' practices in the public sector in general (Lapsley and Oldfield, 2001; St-Martin, 1998) and in the healthcare sector in particular. There is little empirical evidence, either on the role played by consultants in this sector or on the manner in which leaders in this sector use consulting services.

Theoretical framework

Contribution of Schein's work to the process consultation

In the literature on consulting, Schein's (1969, 1987, 1995, 1997, 1999, 2009) work is pivotal. He is a key scholar in the forefront of OD (Gill and Whittle, 1992) and has contributed significantly to the growth of serious reflection on consultation as a process. His writing is based on a certain number of premises that are worth recalling.

The consulting process is based, above all, on a helping relationship characterized by reciprocity and trust (Schein, 2009, p. 11, p. 14). According to Schein (1999, p. 1), this process is based on the central assumption that "one can only help a human system to help itself." In this process, it is crucial that the leader-client collaborate with the consultant throughout the consultation process, and all interventions should be jointly owned by the consultant and the client involved at that stage (Schein, 1995, p. 16). In this process, the consultant basically plays the role of facilitator and works mainly to satisfy clients' needs. Rather than providing the answer, he or she helps clients discover it themselves. The consultant aims to render the leader-client autonomous

(self-empowerment) and allow him or her to become self-aware. Schein (1999, p. 9) claims that, "from the PC point of view, the consultant must […] recognize that *the problem is ultimately the client's* and only the client's. All the consultant can do is to provide whatever help the client needs to solve the problem himself."

According to Schein (1999), this model, based on the client-consultant process and client-consultant cooperation in which the consultant plays the role of "facilitator," which focus on the "how" or the process, is more appropriate than the expert model, which emphasis is on the "what" or the content, or the doctor/patient model, which focus on the "who" or the decision maker. Indeed, in Schein's (1999) view, these two last models entail the client's dependence on the consultant. In the expert model, the consultant brings a special competence to the organization, because this is lacking, the personnel within the organization are not available to intervene, or even because the client needs an independent neutral observer to offer guidance. According to this model, Schein (1999) claims that the consultant assumes the client has correctly assessed his or her needs and that the latter will ultimately accept the consequences of the change being implemented unless the consultant is invited to assist in this task. The leader-client is dependent on the consultant's expertise (the "what") and will assume that his views and interventions are appropriate for the future management of the organization. According to Schein (1999, p. 5), in the expert model, "the client gives away power. The consultant is commissioned or empowered to seek out and provide relevant information or expertise on behalf of the client but, once the assignment has been given, the client becomes dependent on what the consultant comes up with."

In the doctor/patient model, the consultant assumes responsibility (the "who") for the process, from the outset to its completion. The consultant alone makes the diagnosis and takes the initiative in implementing change. Schein (1999, p. 12) claims that the doctor model "puts more power into the hands of the consultant in that he diagnoses, prescribes, and administers the cure. The leader-client not only abdicates responsibility for making his own diagnosis – thereby making himself even more dependent on the consultant – but assumes, in addition, that an outsider can come into the situation, identify problems, and remedy them."

Thus, according to Schein (1999), the two latter models significantly contravene the very nature of the helping relationship between the consultant and the leader-client, as well as the principle of client accountability. He goes so far as to claim that anything beyond the narrow role of helping the leader-client and requiring more specific expertise, whether in finance, accounting or strategy, should be specifically relegated to an expert in the subject.

Schein's proposed model, where the consultant acts as more of a facilitator and oversees closely the process and accompany the leader-client, is presented as a "best way practice" especially because of its universalist character (Golembiewski, 1989; Schein, 2009). The trend in OD tends to confirm this universalist nature by the gradual inclusion of new activities, such as intervention in technostructures, organizational design, human resource management and even business strategy (Cummings and Worley, 2008). The model would apply regardless of the type of organization, private or public, profit or nonprofit, etc. (Golembiewski *et al.*, 1982; Golembiewski, 1989).

Process-consultation and agency theory

An interesting parallel may be drawn between Schein's normative concept of the consulting process and the agency theory. The agency theory places the emphasis on contractual aspects through the delegation of actions or tasks entrusted by a principal

(the person who grants the contract, and in this particular case, the leader-client of a healthcare organization) to an agent (the person who fulfills the contract, in this particular case a management consultant), conferring to the latter a certain measure of decision-making authority on how assignments will be undertaken and the types of results anticipated. This type of situation is likely to give rise to uncertainty, in which case the principal will attempt to limit the agent's power through control measures or incentives in order that the latter act according to the principal's expectations and not solely in his or her own interests (Jensen and Meckling, 1976). The agency theory is based on the premise that the principal and agent have diverging interests, where each acts according to what benefits them most personally (due particularly to moral hazard) while seeking to limit risks or undesirable consequences. Moreover, the relationship is characterized by information asymmetry, an advantage associated with the agent (as a result of adverse selection). Numa (2009) even raises the notion of double asymmetry between the parties: the first linked to the principal's lack of awareness of the knowledge, technical aspects and production costs associated with the agent's intervention; the second linked to the fact that the principal cannot directly observe the management effort deployed by the agent during his or her intervention nor the expertise inherent in the intervention to be conducted. The principal's dilemma consists of clarifying how to lead the agent to act in the expected direction and how to minimize the risk of negative consequences for the agency. The dilemma is even harder to resolve, since the parties operate according to the principle of bounded rationality, thus with imperfect information (Eisenhardt, 1989). Yet, despite control measures implemented by the agent and commitments made by the latter, the principal will find it difficult to develop a strong level of certitude regarding the agent's behavior and the final outcome of his or her actions.

According to Ross (1973), one of the initiators of this theory, examples of agency problems are universal. Indeed, one of the fundamental premises of this theory, information asymmetry between the principal and the agent to the advantage of the latter, is shared by Schein in the field of management consulting. Indeed, according to Schein (2009, p. 27), "[…] in the client initiated formal helping relationship, it is the helpers who have the higher status and power because of their expertise […] Formally hired helpers are in a position to exploit and take advantage of the client […]." This leads Schein to expound further on client vulnerability to the consultant. In the opinion of Schein, only the consulting approach based on the role of facilitator has the ability to remedy this imbalance and establish more reciprocity and complementarity between the principal (leader-client) and the agent (the consultant). Finally, for Schein, a consultative process cannot take place if the two parties do not first agree on the goals and outcome of the intervention. Indeed, according to Schein (2009, p. 17), "when social exchanges don't work properly because the two people involved define the situation differently and are, therefore, using different currencies, the result is anxiety, tension, anger, discomfort, embarrassment, shame and/or guilt."

The agency relationship and problems raised by it has been the subject of numerous analyses without, however, leading to a clear, consensual theory (Numa, 2009). Eisenhardt (1989) feels that this theory could prove interesting and pertinent, especially if combined with another theoretical perspective. Hendry (2002) abounds in the same direction, emphasizing that the field of organizational behavior provides fertile ground for revisiting the agency theory. This is precisely what we are attempting to achieve in this paper based on the work of Schein in the field of management consulting. Moreover, the agency theory happens to be very useful for any study seeking to gain a better understanding of cooperation problems within organizations, in particular when

uncertainty is unusually great or even hard to assess with regard to the outcome of an action or intervention (Hendry, 2002), often the case of consultants' relationships with manager-clients of organizations. Although often disparaged for its narrow, dehumanizing and exaggerated outlook focussed on the "homo economicus" (Perrow, 1986; Hirsch *et al.*, 1990), some authors have breathed new life and a new direction into the agency theory, highlighting the relational strategies that develop between the principal and the agent under the terms of their contractual agreement and questioning some premises underlying this theory (Shapiro, 2005). In this respect, the work of Waterman and Meier (1998) is interesting and sheds light in an original manner on the client-consultant relationship within state bureaucracies, a theme of particular significance in this paper, given interest in consultants' interventions in the public healthcare sector.

The agency theory revisited

Following the example of Eisenhardt (1989), Waterman and Meier (1998) focus on evaluating the pertinence of the premises underlying the agency theory, mainly the issue of goals and/or divergent interests between the principal and the agent as well as the problem of information asymmetry. Their work centers primarily on principal/agent relations in the context of state bureaucracies. They propose eight (8) different situations that may govern contractual relations between the principal (leader-client) and the agent (consultant).

At its base, the agency theory postulates that information asymmetry benefits the agent, or position "D" in Table I, whereas Schein's process consultation is based on the role of facilitator, which corresponds essentially to position "A" in Table I.

Although the two approaches concur on the assumption of information asymmetry benefiting the agent, they differ in terms of the type of behavior to attribute to the agent, mainly opportunistic, as in the agency theory, or altruistic, as in Schein's model of facilitator. The two approaches claim to have a universalistic character in the application of their theoretical premises.

According to Waterman and Meier (1998), relations between the principal and the agent are dynamic, not static, and are likely to evolve in time; the agent is led to share his or her knowledge and expertise with the principal during the development of their relationship and a consensus eventually emerges concerning the goals and outcome of action taken. This results in a review of the assumption of information asymmetry as well as the assumption of goal conflict. By revisiting the agency theory in terms of relations between leader-clients (principal) and consultants (agent), we arrive at the eight following possibilities summarized in Tables II and III.

On the basis of these different possibilities, this research will attempt to determine which scenarios are observed most frequently within the framework of client-consultant relations and their effects on the cooperation that must normally develop when the consultant adopts the facilitator approach advocated by Schein (Table III reflects Schein's

		Level of agent information	
		Weak	Strong
Level of principal information	Strong	C	A[a]
	Weak	B	D[b]

Notes: [a]Classic situation to implement Schein's PC model; [b]classic situation according to the agency theory

Table I.
Four classic situations in the asymmetry of information between principal and agent

perspective). In that perspective and considering the use of Schein's model of process consultation as the theoretical framework in this research, information asymmetry will be appreciated essentially on the basis of the process.

Methods

Research aims

This paper intends to analyze the leader-client/consultant relationship, employing Schein's proposed model of process consultation. More specifically, the article seeks to determine how the model may be applied concretely in current situations encountered in consultancy practice by examining the model's principal lines of inquiry:

- the "vulnerability" or dependence of the client over the consultant on two levels: goal conflict between the principal (leader-client) and the agent (consultant) and the behavior (opportunistic or altruistic) of the agent;
- the consultant' roles (expert, doctor or facilitator) and their impact on the leader-client/consultant relationship; and
- the universalistic character of the model and, more specifically, whether the model is applied in professional bureaucracies of the healthcare sector.

Table II.
Four potential situations in the asymmetry of information between principal and agent in the context of conflict on goals

		Level of agent information	
Consensus regarding goals		Weak	Strong
Level of principal information	Strong	Manager's omniscience that can reveal the consultant's weakness, even incompetence	Power relationship leading to either negotiation or withdrawal of one of the parties
	Weak	Potentially discordant situation Prevalence of the garbage can model	Classic situation according to the agency theory where the consultant's opportunism may be revealed

Source: Adapted from Waterman and Meier (1998)

Table III.
Four potential situations in the asymmetry of information between principal and agent in the context of consensus on goals

		Level of agent information	
Consensus regarding goals		Weak	Strong
Level of principal information	Strong	The consultant is an agent and complies with the client's wishes	Classic situation revealing an *altruistic* behavior from the consultant according to Schein's PC model
	Weak	The consultation process is relegated to play between the most influential actors This may also correspond to a new, unusual situation that neither party has dealt with in the past	The client allows the consultant to take the decision. The classic expert or "doctor" model according to Schein

Source: Adapted from Waterman and Meier (1998)

In this perspective, the article attempts to offer some response to the following questions:

- How to qualify the leader-client (principal) and consultant (agent) relationships in terms of information sharing and exchange? How does the problem of information asymmetry arise? Who does it benefit most, the agent or the principal?
- How relationships evolve during different phases of the consultation process? Is the model of facilitator, considered by Schein (1999) to be the most effective within the framework of consulting practice and the more altruistic from the point of view of agency theory (Hendry, 2002), the one preferred by leaders?
- How the OD model considers specific features of the healthcare organizations that may affect the leader-client/consultant relationship?

Research approach

This paper analyzes the consulting practice of four senior associate consultants in a Canadian consulting firm of 12 employees (junior consultants, administrative staff), located in the Montreal area (head office) in the province of Quebec, based on their experience with various mandates related to the implementation of organizational change in healthcare establishments between January 2005 and December 2008. The firm is a well-recognized one, having specialized in issues of management in healthcare organizations for more than ten years[2]. The senior associate consultants of this firm espouse the general principles underlying Schein's model, meaning that they viewed themselves first and foremost as facilitators or guides in the process of organizational change. They sought to find solutions to organizational dilemmas in a spirit of cooperation and partnership with all stakeholders without attempting to take the place of management in the decision-making process. Their interventions were conducted in such manner as to bolster the capabilities and accountability of members of the organization with regard to their actions and decisions.

This firm serves here as a case study, a research approach which, according to Yin (2009), allows researchers to retain the holistic and meaningful characteristics of real-life events such as organizational and managerial processes. A case is a concrete entity, an event, an occurrence or an action but not an abstract concept or a theory. Both Yin (2009) and Miles and Huberman (1994) agreed to say that a case can cover "sub-cases." In the present research, these sub-cases refer to the 13 mandates[3] of organizational change for which the firm has been called upon by a member of the management team of a healthcare establishment in Quebec (see Appendix 1).

The mandates selected encompass the following common elements: the situation for which the consultants were called in was related to a major change resulting from governmental reforms and requiring a change of mission or general structure of the organization, or putting in place a new management team; the mandate extended over a period of at least three months and covered all phases of the consultation process; the request for intervention was initiated by a member of the organization's management team; the mandate necessitated contact with a significant number of people within the organization.

This research is also grounded into the phenomenology approach (Creswell, 2007; Smith *et al.*, 2009) characterized by an experiential, introspective and reflexive stance (Beeby *et al.*, 1999; Lundberg and Young, 2001; Miller, 1995; Poulfelt and Greiner, 2004; Quinn and Quinn, 2004; Shea and Berg, 1987; Sturdy, 1997). The four consultants acted as reflective practitioners (Schön, 1983) and participated in a process of reflection on

their own practices. They agreed to analyze 13 mandates of organizational intervention in depth. This approach, based on reflexive experiences, is very common in the world of consulting. Indeed, most authors who have written on consulting (Blake and Mouton, 1983; Block, 2011; Lippitt and Lippitt, 1978; Schaffer, 2002; Schein, 1969, 1987, 1999, 2009; Schön, 1983) have used their personal experiences as consultants in conducting their research. This has allowed them to discard some of the fundamental concepts of the profession. Furthermore, a number of writers (Berry and Oakley, 1993; Lapsley and Oldfield, 2001; Poulfelt and Greiner, 2004) believe that the practice of consulting has such an aura of secrecy that one often needs to be or to have been a consultant oneself in order to do relevant research in the field (Mitchell, 1993). A number of authors (Lalonde, 2011, McKinney-Kellogg, 1984; McLachlin, 1999) have conducted research based on the personal experiences of various consultants.

Data collection and classification

The data collection officially started in the spring of 2009 and the researchers had access to all the relevant material requested. Data on the goals and stages identified in the contractual agreements[4] of each case were collected, as were observations by consultants over the course of the mandate, reports submitted to leaders throughout the mission, material from interviews of management and personnel, exchanges of correspondence (letters, memos, e-mails, etc.), and notes on meetings among the consultants themselves (see Appendix 2, step 1). All these material were recorded in the archived files of the firm. After this first round of data collection, the second round consists of group interviews with the senior consultants in the purpose of strengthening the analysis made by the researchers. Although usually working in tandem for each sub-case, the four consultants were not all involved in the 13 sub-cases studied. For this reason, the researchers conducted three interviews with only two of four consultants and a final "wrap-up" interview was conducted with all four consultants. Each consultant is identified by the alias "participant 1," "participant 2," "participant 3" and "participant 4."

The writing up of each sub-case respected the chronology of events and employed the concepts of stages in the consulting process, that is, the entry phase, the diagnosis phase, the planning/implementation phase and the concluding phase (see Appendix 2, step 2). Following the general principles stated by Yin (2009, p. 31), the sub-cases served as the main unit of analysis and the phases of the process consultation as embedded units of analysis.

In the literature studied, the consultation process during a mission is divided into the following phases (Block, 2011; Cummings and Worley, 2008; Greiner and Metzger, 1983; Kubr, 2002; Lescarbeau *et al.*, 2003): the entry phase, the diagnosis phase, the implementation phase and the concluding phase. It appears that this division of the consultation process into phases allow the researcher and the practitioner to better describe each specific intervention in chronological order. This facilitates the classification of the material collected and the presentation of findings. For each phase, we have pinpointed the key factors which, according to the literature (Brown, 2011; Phillips *et al.*, 2013), must be considered in order to evaluate the conditions necessary for the success of a consulting mission. These factors are presented in Table IV.

Thus, in the entry phase, Schein (1997, 1999, 2009) invites us to ask "who the client is." For example, in McKinney-Kellogg's (1984) study, the client is defined as the contact person within the client organization with whom the consultant considered himself or herself to have the most significant client-consultant relationship. It is usually the person

who hired the consulting firm to work for the client organization or the person with whom he or she spent the most time. In addition, the consultant must be in contact with a person in authority within the organization, otherwise his mandate will probably not get off the ground, an opinion shared by most consultants (McKinney-Kellogg, 1984). Finally, according to the authors, the consultant must also be introduced to the client system and his mission must be clearly presented to the members of the organization (Lescarbeau *et al.*, 2003). In the literature, we have found two factors that determine the entry phase: the person with whom the initial contact is made, and how the consultant is introduced and his mission presented to the members of the organization.

In the diagnosis phase, it must be pointed out that clients often have their own interpretation of what goes on inside an organization. The diagnosis phase therefore tends to be omitted, as the leaders consider that they have enough information on which to act (Bottin, 1991; Verstraeten, 2007). It is thus sometimes difficult to get beyond the "first impressions" stage and to establish a diagnosis of any substance (Bottin, 1991; Lescarbeau *et al.*, 2003); this may be a problem when it is time to take concrete action. Most authors agree that the client and the client system, especially in public organizations (Buono *et al.*, 1995; Gilbert *et al.*, 2007) such as those studied here, must participate actively in formulating the diagnosis and share a common interpretation of the problems or dilemmas facing the organization when the changes are implemented. In addition, the information collected must be based on a variety of valid, relevant sources. If the leaders do not participate during this phase and the data is hastily collected, the members of the organization may not feel bound by the recommendations, which are based in part on this important stage. Therefore, two key factors have to be considered in the diagnosis phase: the level of responsibility of the parties involved in formulating the diagnosis, and the scope of the diagnosis (exploratory, extensive, targeted, etc.).

The implementation phase may prove to be crucial for the members of the organization. The proposed changes often falter here. Besides the level of responsibility assumed by each person, issues are often raised by the client system during the implementation phase. These two aspects must be taken into account in the research. Finally, in the concluding phase, most authors (Block, 2011; Lescarbeau *et al.*, 2003; Kubr, 2002) consider a formal evaluation of the consultant's intervention to be essential. A follow-up undertaken a short time after the consultant's visit is also seen as a factor in maintaining successful business relations.

Based on these themes (that serve here as "key information" between the leader-client and the consultant) identified in the literature on consulting in each of its phases (Block,

Entry phase		Diagnosis phase		Implementation phase		Concluding phase	
Who is involved?	How?	Who is involved?	How?	Who is involved?	How?	Who is involved?	How?
Nature of the initial contact/quality of the informant(s)		Level of responsibility of the manager assigned to follow the process				Evaluation of the interventions performed by consultants	
Introduction of the consultant in the organization/nature and quality of the communication with the client-system		Type of diagnosis needed (content, scope, data to be collected)		Issues raised by members of organization during the process		Consultant assured a follow-up	

Table IV.
Main information collected for each phase of the consultation process

2011; Kubr, 2002), a transversal analysis (Miles and Huberman, 1994) was performed to produce a synthesis of all the materials collected for each phase (see Appendix 2, step 3). The classification of all the materials collected is based on an inter-rater codification using N'Vivo software. The level of agreement between the two raters was between 82 and 94 percent.

Limitations of this study

This paper explores the nature of the leader-consultant relationship, based on the experiences of a single consulting firm. Moreover, this firm only presents one category of consulting services, the total market encompassing both small firms such as the one studied, larger firms, and solo practitioners. Various studies (Lapsley and Oldfield, 2001; Sturdy, 1997) reveal differences in practices and perceptions between consultants working for large firms and those employed by small firms or working alone. Consequently, it is necessary to significantly broaden the field of investigation to obtain a more accurate depiction of the reality of consulting practices. This research is part of a more extensive project aims to describe consultants' interventions in the public sector of health and social services in Canada and, more specifically, relations that consultants have with clients and the organizations that employ them. Through the use of a single case study (Yin, 2009), our purpose is to pinpoint research avenues worthy of further confirmation. However, based on the advices provided by Miles and Huberman (1994, p. 28), the case selected in this research can be defined as theory-driven and "critical" which permits "logical generalization and maximum application information to other cases." This point of view is supported by Flyvbjerg (2006, p. 228) who invite researchers to not underestimate the power of one example.

Main results

Entry phase

According to the organizational model recommended in the literature, two important aspects must be considered during the entry phase: the type of contact that consultants developed with the leader-client, and how the consultant is introduced to other members of the organization. What may be observed in this respect? First, it would appear that the consultants made rapid contact with the most significant individuals involved in the supervision of their mandate and that the decision-making process that led to their hiring was often conducted in a collegiate manner:

> The individuals with whom we interact are not always directors-general. It is important to note that in healthcare establishments, decision making is based on a collegiate approach and the human resources manager or other program managers are the persons with whom we interact most often. Our primary reference source is not necessarily the director-general and, in any case, he will inevitably consult upper management prior to entrusting a mandate to a consultant (Participant 1).

In most cases, the initial contact was someone in authority in the organization, the director-general or someone in upper management. In two cases, the consultants were contacted by senior or even middle managers and these individuals were members of the management team and had the necessary authority to establish the terms of the mandate with the consultants. Beyond the first contact, the director-general and some members or all the members of the management team became the main reference throughout the consulting process. Finally, there was one special case which created a

partnership among a number of establishments and, in this case, the consultant's contact was a committee of partners:

> In the past, our firm has worked with a spokesperson composed of a group of managers and even a group of independent, self-governing establishments seeking to develop a partnership. This is a completely different way of working, particularly in the case of a group of establishments, because we have to deal with several individuals with potentially divergent views and interests in the outcome of the mandate (Participant 2).

It is important to note that the leaders' request was not publicly tendered as is commonly done in the public sector. Rather, the leaders contacted the consulting firm because of its renowned expertise in the field of healthcare. The leaders were familiar with the consultants, either professionally or from favorable references from colleagues which may reduce the adverse selection noted in the agency theory. In most cases, leaders expressed a need for both expertise and support. The management team had previously discussed the possibility of engaging consultants and had had this decision ratified by the board of directors.

Preliminary discussions were held, first with the leader, and second with targeted members of the upper-management team, about the reasons for calling in consultants. These preliminary discussions took place within the context of face-to-face meetings, with two exceptions where telephone interviews replaced personal encounters due to geographical distance. These meetings consisted of a brief explanation by the contact person of their needs, along with communication of management's expectations to the consultants. Nonetheless, in one-third of all cases, these meetings were fairly brief and latitude to reformulate or significantly question the mandate was rather limited. Following are some remarks made by consultants in this respect:

> Quite often our manager-clients already have an idea of what they expect from us in terms of […] I would say […] how to move a file forward or, then again, heighten employee awareness or mobilize employees (Participant 2).

> Since the contents and budgets associated with consulting firm mandates are, in many cases, discussed during meetings of the Board of Directors, it can sometimes prove difficult to change the terms of a mandate (Participant 3).

These findings led consultants to be prudent regarding information collected during initial contacts and exercise caution in the pursuit of the consulting process:

> Obviously, we must clarify the reasons why a manager or a team wants our services. This can help preclude a move in the wrong direction leading to confusion and dissatisfaction. But sometimes, despite our best efforts, unexplored, undetected issues or issues not raised by members of the organization will surface during the course of the mandate (Participant 3).

The way that consultants were introduced to the organization varied greatly. In a third of the cases, the consultants were presented and introduced to the organization and overall directives were then issued to the personnel about the role the consultants would eventually be called upon to play within the organization:

> Sometimes management informs employees of our presence before we arrive. Employees already involved in working committees and the unit targeted by the consulting intervention are generally already aware of our impending arrival (Participant 1).

> In healthcare establishments, there are committees of professionals made up of physicians, nurses, social workers and others with a great wealth of expertise. There are also trade unions to consider, whose role consists of caring for and protecting their members. Based on our

> observations, employees rarely contradict their peers or trade union representatives. Failing to consider these "authorities" is, in our opinion, a grave error. From the very start, one must avoid neglecting spokespersons of importance (Participant 4).

In another third of cases, this presentation was more formal. A meeting with those likely to be involved was held and they were able to pose questions and propose strategies and objectives they would like to discuss with the consultants. In the last third of cases, the impending arrival of the consultants was announced through internal communication. Once management had made the commitment, the consultants had to introduce themselves during their initial contact with members of personnel:

> I remember a mandate where contract negotiations took place solely with the director-general. When the time came to meet the management team, they were suspicious, to say the least. However, the managers did not blame us for not having been consulted beforehand, indicating that they were used to these kinds of "hidden" initiatives spearheaded by their director. Nonetheless, it is a poor way to start! (Participant 4).

In sum, and based on the results collected, it would appear that in the entry phase, both the agent and the principal seek information within the organization that will serve to clarify the nature of the mandate leading to an intervention within the organization. Thus, the entry phase has been experienced as an exploratory stage to retrieve information, and the approach between the two parties seems to be symmetrical, rather than asymmetrical. It is also important to highlight the collegiate nature of decision making in healthcare establishments and stakeholder sensitivity to the fact of being consulted as to the mandate and the role played by the consultant. Data show that this dimension is present in most of the situations presented, but it is not uniformly taken into account by the initiators of consultation projects. Indeed, in about one-third of all cases, members of the organization likely to be affected by the consultant's intervention were not systematically associated with, or informed of, the definition of the mandate entrusted to the consultants. This situation greatly complicated the consultant's task, particularly during phases to implement change as we will see in the next sections.

The diagnosis phase

The level of responsibility of the senior managers assigned to follow the consultation process and the type of diagnosis needed for a specific mandate are two dimensions to look at the diagnosis phase. The consultants recognized the importance of this phase in the process:

> I believe that a diagnosis is essential in the type of mandate entrusted to us. And the idea of the diagnosis, or collecting information on the organization, paves the way for action (Participant 2).

> The diagnosis, especially if built with the help of others, will generally help clear the way. People are usually able to identify what should be reviewed and changed in ways of doing and acting (Participant 3).

The activities related to the diagnosis phase, such as data collection, conducting interviews, synthesizing materials collected and preparing a first progress report, were principally the responsibility of the consultants of this firm in more than half the cases. Regular meetings were held during this phase to keep the manager informed of developments and sometimes also to clarify certain perceptions. In accordance with what is recommended in practitioners' literature, the idea of properly identifying the level

of analysis to target in order to complete the diagnosis was deemed fundamental by the consultants. The fact of collecting a wealth of privileged information from a diversity of groups of actors gives the consultant (agent) a head start over the leader (principal):

> The geometry of our interventions is variable, but it is always based on an analysis of the situation. Evaluating the situation is a step in the approach that serves us well and helps us choose the most appropriate interventions (Participant 4).

However, the consultants raised a few problems associated with the completion of a thorough diagnosis:

> What is frustrating is that we often have a hard time obtaining reliable factual data other than perceptions or impressions (Participant 4).

> Sometimes we ask for data or statistics that management and staff are unable to provide. And when we do find the information, it is not always recent or explicitly related to what we are seeking to learn (Participant 3).

In three cases, the consultants had to revisit the leader's evaluation of the situation. This was accomplished through a method of sharing observations in preliminary discussions. In the latter three cases, this phase was skipped and the consultants were rapidly immersed in the other phase, that of direct intervention in the client system:

> Several clients fail to understand why they must pay for a diagnosis. Unfortunately the diagnosis is often viewed as a waste of time. Managers believe that they already know what the problem is […] except that sometimes, we show them that they were way out in left field (Participant 1).

> When we place ourselves in the manager's shoes, it is easy to understand that he or she does not want the consultant's intervention to destabilize him. The manager does not want to purchase problems and he does not want the consultant to place a stick of dynamite under his chair. The consultant must find a line of conduct between understanding this fact and maintaining a measure of thoroughness in his approach (Participant 2).

Sometimes, leaders arrive with ready-made solutions that they ask the consultants to apply. They have already come up with their own diagnosis and do not always leave the desired margin of manoeuvre for the consultants to raise questions and validate the diagnosis. According to Bottin (1991) and Verstraeten (2007), the leader is generally action-oriented, wanting the quickest and least expensive result possible, in terms of morale, productivity and consulting fees. These authors claim that usually leaders are not looking for a diagnosis. Rather they generally have tacit assumptions of the nature and causes of the problem they are experiencing, which they come to believe accurately reflects the situation.

In sum, during the diagnosis phase, the agent (consultant) would appear to have a certain advantage over the leader-client (principal) in terms of access to unusual (never before collected in this form) and privileged (collected and revealed to the consultants confidentially) information. However, in some cases, access to such information can be very labor intensive, managers may be tempted to skip this phase to save costs, and sometimes the quality of the information collected by the consultants is not reliable.

The implementation phase

It was difficult to differentiate between the diagnosis phase and that of planning/implementation since these appear to be so inextricably linked in consultancy practice. Indeed, the very fact of consultants meeting employees, conducting interviews with key

individuals in the organization, and holding discussions with the management team are actually occasions for starting to bring about the expected changes:

> There was quite the information collection process and, obviously, a more conclusive diagnosis carried out with the director and the department head. The diagnosis was then shared with the entire team to obtain their firm commitment to implement changes and take necessary action. We guided them through the process (Participant 1).

> […] in the wake of the diagnosis, more "refined" interventions took place with the directors or all the managers. In one case, for example, I had two meetings only with the director-general followed by individual meetings with persons from other departments […] in order to determine what decisions and concrete action should be implemented (Participant 3).

Analysis of activities during this phase led to a variety of findings. In a third of the cases, planning and initial implementation of interventions tailored to the situation were essentially at the initiative of the consultant. In these cases, leaders had a tendency not to get involved and to remain on the sidelines, at least at the outset. In the second third, the implementation phase was done jointly with senior management and a limited number of people were associated with it. This collaboration proved fruitful and gave rise to a solid mobilization of the organization but on quite limited issues and on technical grounds such as: designation of a committee in charge of the implementation of consultants' recommendations, timeline of this implementation phase, general guidelines and logistics to put in place before starting any changes, the final decision to be taken by the board of directors, etc. Finally, in the last third of the cases, the consultants left the organization and did not directly and significantly participate in the actions to implement change, leaders opting instead to have the senior manager responsible for the targeted unit follow through with the process himself.

It is crucial to emphasize that, in a relatively high number of cases (ten out of 13), employees revealed significant scepticism about the implementation of changes, in particular in a context where the initiative was left entirely to senior management or one of its members. This was reflected in such things as their inability to reach a decision, their lackadaisical approach or the indifference demonstrated in their management style, employees' suspicion of the designated manager or senior management, open disagreement of a manager with the solutions proposed, and a lack of cohesion and common vision within the management team. In fact, it would appear that in healthcare organizations, leaders get involved in an escalating indecision (Denis *et al.*, 2011); when the times come to implement the recommendations proposed by the consultants; the results of such indecision is an amplification of local arbitration and political games among the most influential players.

Behavior consisting of blaming leaders of the change process inspired caution on the part of consultants. In fact, this could be used simply to shift responsibility to others. And if consultants fall into this trap, they also risk falling into a vicious circle and becoming part of the problem rather than part of the solution (Shapiro *et al.*, 1993). At the same time, actors frequently complain about leaders in a changing environment displaying a lack of vision and direction, as well as paralysis in decision making. It is best to acknowledge that the role of consultants is truly situated at the confluence of all these forces and tensions (Pellegrinelli, 2002) and that they are in a position to assist both leaders and all of the employees to come to terms with this, a task that many authors deem challenging (Beeby *et al.*, 1999; Buono *et al.*, 1995) and paradoxical (Whittle, 2006).

In sum, management of the implementation phase can follow very different courses from one organizational situation to the next. Only in a third of the cases did the

consultant appear to exercise more direct control over the situation (namely the role of "doctor" in the typology of Schein and asymmetry in favor of the agent in the agency theory). Generally, speaking, the consultants in the firm under study indicated having adopted the following line of conduct:

> We examine all the best approaches. The solutions that we intend to propose are solutions that will be developed with the teams to implement with the teams, and not consultant solutions. In our exchanges with clients, we tell them: "The file we have just completed is not our firm's file, it is your file. You are the ones who will continue to pursue it and breathe life into it. As a consulting firm, there is no advantage for us to offer you recommendations that will be shelved, because they will help no one" (Participants 1, 2, 3, 4).

The concluding phase

At the close of their mandate, the consultants of the firm under study indicated proceeding as follows:

> At the close of a mandate, we re-examine the service tender and evaluate with the client the activities carried. We then ask, "Are you satisfied with the manner in which the mandate was carried out? Are there aspects of the mandate that you would have preferred to be carried out differently? Have your expectations been met, even exceeded? Did we miss anything?" We want to know. Each phase in the mandate will be reviewed to ascertain whether we missed anything. This is how we proceed (Participants 1, 2, 3, 4).

Based on the evaluation mechanisms implemented by this firm during the concluding phase, we noted that in most cases, the leaders of the organizations evaluated the consultants positively. Indeed, the leaders expressed their satisfaction with regard to the professionalism of the consultants, their communication skills, the rigorous nature of the process, their resourcefulness and the calibre of the written reports. These positive comments were echoed by a goodly number of the employees with whom the consultants were in contact, who mentioned their ability to listen, their empathy, their skills and their availability. In only one case was there a formal evaluation using an evaluation form, whereby the personnel strongly expressed their satisfaction with the same elements. Nonetheless, in a third of all cases, the consultants received no feedback, despite their requests for meetings for that purpose.

Despite wholly positive evaluations of the consultants, the latter were only called back for a follow-up of the original project in four cases out of 13. On the other hand, there was no systematic effort on the part of the consultants to contact management in these organizations to inquire about the status of the projects in which they were involved.

After all is said and done, and although leaders indicated their satisfaction in most of the situations analyzed, the consultants of the firm under study did not possess all the information required to determine where concrete action and specific measures had been implemented by members of the organization – and the leaders more particularly – to resolve the problems for which the consultants had been hired initially. In general, at the concluding phase, the information asymmetry seemed clearly to benefit the leaders-clients, since they had all the material provided by the consultants and could do whatever they wanted with it.

Given the findings from the concluding phase, consultants wonder about the opportunity of a follow-up visit to these clients, as well as the need for formalized evaluation sessions. Results show that, while they were evaluated positively by the leaders who called upon their services, this was done at the end of the project, usually in an informal fashion. Therefore, consultants do not know whether what was started

will continue because they are not systematically requested to monitor progress. This finding is consistent with various other studies (Buono *et al.*, 1995; Lapsley and Oldfield, 2001; Smith, 2002) that depict this sort of behavior as common in public organizations. For their part, Shapiro *et al.* (1993) believe that it is wise at a certain point for leaders and managers themselves to intervene alongside a consultant. These authors see the indefinite involvement of consultants as maintaining the organization dependent on their services. Such scholars, including Smith (2002), claim that leaders and managers are reluctant to fully endorse consultants' recommendations and to hold themselves accountable.

Roles of facilitator, expert and doctor

A review of the accumulated data prompted some critical reflection by the consultants about their own practices in the overall process (see Appendix 3). They also noted that the cooperation from the client and the system-client was not optimal and that the consulting process could be improved. They also noted that constraints of costs were important issues in the healthcare sector. In summary, the facilitator model put forward by Schein as the "one best way" of management consulting is difficult to implement and does not suit indifferently all situations encountered during the consultation process. The main obstacles identified by the four senior consultants are summarizes in Table V.

In most cases studied, it is important to note that consultants were called in because the management team or senior management were unable to find by themselves solutions to the issues confronting the organization, believed they would not be able to reach a solution without outside assistance and lacked the appropriate time to initiate a rigorous and well-organized process. In most cases, leaders sought help that they hoped would lead to a solution in the near future, and the time allotted to the consultants to organize the process was relatively short.

Obstacles	Levers
Demand for quick fix solutions	Managers opened to new ideas and new ways of doing things
Short term vision of complex situations	Client and system-client involved in the process
Narrow focus on low cost investment	Client work with the consultant instead of consultant work for the client
Assignments expressed in terms of means instead of strategic objectives to attain	Share of insights between client and consultant
Personal agendas that interfere with the efforts of change particularly front-line supervisors and staff	Opened discussions about assignments and time taken to discuss important issues
Ill-defined objectives	Consultant's assignments and roles presented formally to the members of the organization
Focus on solving problems without a grounded diagnosis of the situation	Person responsible to supervise the intervention with the consultant has authority to take decisions
Focus on rationality with minor considerations for the emotionality of the situation	Formal evaluation of the performance of the consultants at the end of the process and appreciation of the output
Confusion about what is really expected from the consultant in terms of roles	Diagnosis based on accurate data
Lack of clarity on mutual responsibilities while the process was underway	Consultants keep managers informed of the overall process and of any change in the agreement

Table V.
Synthesis of obstacles and levers in achieving the facilitator role defined by Schein

The initial formulation of the leaders' request often made reference to new or additional expertise, giving consultants fairly significant latitude in conducting the process (the role of expert) or even "*carte blanche*" (the role of doctor). In only three cases was the initial request couched in terms of support, with the designation "facilitator" never explicitly arising:

> I have clients who will tell me, "You are free to conduct the file as you see fit." Of course, this heightens our responsibility, but at the same time, I view it as a sign of trust (Participant 3).

Following preliminary discussions during meetings in the entry phase, the consultants emphasized the importance of a member of the upper management team being engaged in the process and actively collaborating throughout. This principle was accepted by most clients but not always followed by them:

> We also position our service tender as directed towards coaching and providing support to management. We do not want to take their place, we want to help them in the classic sense of the term (Participant 1).

> We are the consulting specialists. We help them see things that they do not see or no longer see. They are the healthcare specialists. They help us gain a better understanding of their mission, goals, administrative constraints, ministerial and public expectations, the particular characteristics of certain clienteles, etc. Cooperation is optimal when each excels in their respective field of expertise (Participant 2).

> Of course it is much simpler to be on a peer-to-peer basis with the director-general, and some consulting models are based on this idea. But the situation is a bit different in healthcare establishments where authority is dispersed and spread out among a multitude of powerful players (Participant 3).

Nonetheless, the consultants were actually left to their own devices in about a third of the cases and had to shoulder responsibility for the entire process. A lack of time and the desire to allow the consultants to play an independent and "neutral" role were generally cited by leaders to justify this distancing of management. The consultants have rather seen this position as an excuse to avoid making decisions that may displease some influential actors:

> I had a mandate where I almost never saw the director-general. His deputy-director was my principal contact. But at a certain moment in time, we had to insist on a meeting with the director-general. In the course of our mandate, we noted that the managers did not agree among themselves and the director-general was not taking decisions. We finally realized that the director-general wanted us to take the decisions in his stead (Participant 3).

Most often, consultants alternated between the roles of expert and coach and tailored their interventions so as to encourage the greatest possible mobilization on the part of the client and the client system. These modulations of roles were really attempts to encourage the leader-client and the client system to become more actively engaged in the consulting process. To that end, the consultants set up a system of regular follow-up meetings with leaders to include them in the actions being taken within the organization and to discuss and share their perceptions of the situation within the organization. The consultants saw these meetings as a way to bring leaders and their management teams into the consulting process. Leaders and managers systematically attended these meetings and expressed satisfaction with being kept abreast of developments. During meetings with employees, the consultants listened attentively to their views, while inviting them to share any concrete solutions they would like to see

applied to improve the functioning of their unit, their group or the organization as a whole. These meetings were conducted in such a way that the solutions or necessary actions came from the client system and not the consultants. Throughout the consulting process, the consultants acted as a sort of "bridge" between leaders and employees and adapt their roles according to the current situation:

> In a professional bureaucracy like a healthcare establishment, it is very clear that one must be at ease with what I would refer to as the ambiguity of power. We can share a cohesion of views with the director-general, and although this is a necessary condition, it does not always suffice to bring about the changes desired by management. In some cases, privileged and close relations with the director-general may even be viewed with suspicion by other members of the organization who may doubt our objectivity or impartiality (Participants 1, 2, 3, 4).

Discussion and conclusion

This research's objective was to analyze the nature of the leader-client/consultant relationship, using the agency theory to revisit some basic principles underlying Schein's model of the consulting process. In reference of the diverse scenarios put forward by Waterman and Meier (1998), the data collected from 13 cases of organizational intervention by four consultants in the same management consulting firm is revealed in Table VI.

Following are some theoretical and practical implications of these results.

Theoretical implications

(A) The framing of management consulting' models in the field of organization development. Despite the important contribution of Schein's (1969, 1999, 2009) approach and its predominance in the field of OD, and in line with various scholars, this research has brought forward certain limitations to his approach in particular with regard to three premises concerning: the client vulnerability, the incompatibility of roles between expert and facilitator, and the universalist nature of the model. For instance, our research highlighted that the leader-client's position in the relationship is strong at the entry and at the concluding phases. At the entry phase, the leader-client have determined, in partnership with the consultants, the terms of the contract and of the assignment, as well as the parameters of the diagnosis, and had the final word as to which follow-up will be done to the consultants' interventions and recommendations. At the diagnosis phase, the leaders-clients accepted to delegate the operational aspects to the consultants which may give a stronger position to the latter in the relationship at this phase. Finally, the implementation phase was a unique one where all actors were

Table VI.
Four potential situations in the asymmetry of information between principal and agent in the context of consensus on goals at different phases of the consulting process

Consensus regarding goals		Level of agent information: Weak	Level of agent information: Strong
Level of principal information	Strong	At the *concluding phase*, the leaders solely decided what will be the follow-up to the consultants' recommendations	At the *entry phase*, both parties seek optimal information to start the assignment on good grounds
	Weak	The *implementation phase* is characterized by an escalating indecision and relegated to political games between the most influential actors	At the *diagnosis phase*, consultants may collect unusual and privileged information from different stakeholders

Source: Adapted from Waterman and Meier (1998)

involved and neither the leader-client nor consultants fully master the process and the outcomes at this phase.

Many authors (Fincham, 1999; Nikolova and Devinney, 2009; Sturdy, 1997) questions one of the starting points of Schein's model, knowing that the client needs help, that he is confronted with a problem for which he lacks the response, and that the very formulation of the problem needs to be reconsidered. This starting point is based on the presumption that the manager-client is limited, disadvantaged and/or vulnerable with regard to the tasks he must accomplish and that he needs an external agent to see clearly. Sturdy (1997, p. 390) criticizes this vision of manager-client vulnerability: "[…] in highlighting the insecurity and vulnerability of managers, their active role in the consultancy process and its interactive nature tend to be neglected. For example, managers are often critical of, and resist, consultants and new ideas and, in turn, consultants respond to and seek to anticipate such concerns. Also, by focussing on why managers adopt ideas and their anxieties, consultants tend to be portrayed as confident and in 'control' rather than being subject to similar pressures and uncertainties." Also, managers are increasingly demanding of consulting services, thus contributing to the proliferation of models (Williams, 2004), methods and toolkits that the competition might employ. A mastery of the latest models is the consulting industry's stock-in-trade and consultants, for fear of being shut out of the market, hasten to acquire the desired expertise to eventually sell it to their clients (Carter and Crowther, 2000; Fincham, 1999; Gill and Whittle, 1992; Lalonde, 2014; Shapiro *et al.*, 1993). Therefore, the nature of contracts and business relationships between manager and consultant (Shapiro *et al.*, 1993; Simon and Kumar, 2001; Stumpf and Longman, 2000) seems somewhat obscured in Schein's model, due to his emphasis on the disinterested and essentially therapeutic quality of the process.

Regarding consultants' roles performed throughout the consultation process, many researchers (Burke, 1997; Church *et al.*, 1994; Schaffer, 2002) believe that, in fact, to be truly effective in satisfying managers' expectations in today's organizations, consultants should offer a blend of content consulting (or the expert approach) and process consulting (or the facilitator approach). For instance, a study by Church *et al.* (1994) found that practitioners perceive the field of OD today to be focussed more on business effectiveness and productivity issues than on humanistic concerns and orientations of the past. Given these new trends in contemporary organizations, the scope of consultants' roles must also be fairly extensive (Berry and Oakley, 1993; Kubr, 2002). In that light, Schein's model seems somewhat restrictive, considering the emphasis placed on consultation as a process rather than as content. Schein (1999) suggests that the expert form of relationship is based on a power relationship in the consultant's favor. This premise is questioned by various scholars (Lapsley and Oldfield, 2001; Sturdy, 1997). Furthermore, does not mastery of the consulting process and its attendant helping relationship suggest that the consultant already possesses a certain expertise in the behavioral sciences?

Finally, a number of authors have questioned the universalistic pretention of many consulting models, including Schein's one, and have underscored the particular nature of interventions in the public sector. Specifically, the multiplicity of interest groups tends to politicize the process (Chapman, 1998; Cobb, 1986; Gilbert *et al.*, 2007; Glassman and Winograd, 2004; Lalonde, 2014; Lapsley and Oldfield, 2001; Martin, 2000). This pluralism, combined with the ambiguous goals that public organizations pursue, creates a context conducive to a lack of accountability (Buono *et al.*, 1995). The consultant may be perceived by public sector managers as an additional actor

interjecting into an existing struggle for power and status within the organization. In an in-depth analysis of consultants' interventions in an American primary school, Buono *et al.* (1995) find this type of organization characterized by ambiguity and diversity both in its goals and in the nature of its relations with interest groups. To succeed, the consultant must bring key actors in the process at all levels of the organization to work together in close cooperation. Following Buono *et al.* (1995), Glassman and Winograd (2004) believe that political dimensions are inherent in public organizations' dynamics and consultants must learn to cope with them (Cobb, 1986). The issues of accountability may be so delicate that managers tend to be cautious in decision making to avoid alienating political support and upsetting a fragile organizational equilibrium of various interest groups (Lapsley and Oldfield, 2001). That might explain the collective and, at times, the messy character of the implementation of change which, in public organizations such as the ones encountered in the healthcare sector in Canada, involved a plurality of actors.

(B) Agency theory. The agency theory has been revisited in many fields (Shapiro, 2005), and some of the assumptions underlying this theory have been challenged (Fong and Tosi, 2007; Nikolova and Devinney, 2009; Pepper and Gore, 2014; Sharma, 1997; Waterman and Meier, 1998; Wright *et al.*, 2001). Our research attempts to contribute to the revision of some of them but also to its enlargement. We explored interfaces of this theory with the field of OD, an avenue deemed promising by several authors (Eisenhardt, 1989; Hendry, 2002; Wright *et al.*, 2001) particularly in situations where a structure of cooperation prevails. To achieve this, we drew on the work of Schein in organizational consultation. Schein's work is aligned with the philosophy of OD promoting agent behavior that is altruistic, cooperative and consensual, a philosophy that contrasts sharply with a presumed opportunist agent approach resulting from a conflict of goals with the principal, as promulgated by agency theorists. By aligning the two outlooks, we were able to determine some convergences (presumed vulnerability of the principal facing the agent), but also some differences (conflict vs cooperation in relation to goals). Having chosen the empirical field of targeted interventions in the healthcare sector, it was possible to contextualize and refine the theoretical models proposed. Indeed, like many authors have already stressed (Perrow, 1986; Shapiro, 2005; Waterman and Meier, 1998), leader-client/consultant relations in professional bureaucracies in public sector cannot be reduced solely to a client/principal vs consultant/agent dyad. Indeed, the decision to call upon an external consultant to intervene in an organizational arena characterized by professional pluralism, the presence of several stakeholders having different, very divergent expectations (Denis *et al.*, 2011; Suddaby and Greenwood, 2001), and the collegiate nature of decision making are conducive to tempering the assumed universalism of theoretical models proposed and drawing on a contextualized approach instead (Pettigrew, 1987). In addition, Schein (1997) himself is led to ask, "Who is the client?" in a relationship involving a third party like a consultant. This result echoes the remarks of Shapiro (2005) and Perrow (1986) to the effect that the principal/agent relation cannot be reduced to an out-and-out dyad. Moreover, like the ideas advanced by Waterman and Meier (1998), the results of this study tend to show that nothing is truly black or white and that power associated with the possession of information and privileged knowledge is dynamic rather than static. Thus, during the consultation process, the consultant (agent) is led to change roles – moving alternatively or concomitantly from the role of facilitator to that of expert, or "doctor." Consequently, and similarly to the results found by Nikolova and

Devinney (2009) in their research, the asymmetrical character of the principal/agent relation does not always lean in the same direction. The control of information can even escape to both principals and agents, and become a power issue left to local arbitration between various stakeholder groups (Suddaby and Greenwood, 2001).

Furthermore, other aspects of the agency theory, namely adverse selection and moral hazard, could not be verified directly in our research. These facets of the agency theory may have some importance insofar as the world of organizational consultation is characterized by weak barriers to entry and by the fact that it is not a profession in the classic sense of the word, but a quasi-profession at best (Etzioni, 1969), not regulated by any officially recognized accreditation body. The fact that the firm used in this research is recognized in the healthcare sector and renowned for its expertise may lead one to believe that the recruitment by the leaders-clients was not entirely blind. Still, given the actual state of practice, it may prove difficult, even impossible, for the principal to properly evaluate the professionalism and competence of consultants, even more so since contractual agreements are behavior-based contracts not outcome-based contracts and rarely lead to an obligation of result on the part of the agent (Eisenhardt, 1989; Sappington, 1991). Only repeated experience with consultants and word-of-mouth among colleagues, a practice that appears to be widespread among managers in the healthcare sector (Lalonde, 2014), might eventually lead to greater discrimination in services offered on the market.

Finally, considering the clear positioning of the firm in this study in favor of the basic philosophy underlying OD, we assumed that the consultants worked using a collaborative, altruistic and consensual approach. This point of view is supported by other researchers such as Phillips and Bosse (2013) and Fong and Tosi (2007) who found that conscientiousness plays a role in the agent's behavior and that opportunism has been overstated in the agency theory. However, we were unable to verify directly the consultants' conduct in the field. Still, the variety and wealth of material to which we had access as researchers made it difficult to doubt the likelihood of the concrete application of this philosophy in the field. In fact, the main limitation here was not having accounts from clients and members of the organizations in which the consultants intervened.

Practical implications

This analysis raises a number of questions about the general understanding and applicability of the process consultation as defined by Schein. Perhaps the four consultants have not perfectly mastered the interpersonal skills that Schein's model presupposes (such as empathic listening, problem-solving skills, teambuilding abilities, capability of not directly interfering in decision making). One may also conclude that the model does not always respond to the expectations and needs of managers and that, for many consultants, it is difficult to adopt only one role throughout the consulting process. One may also question its realism in a context of interventions in public organizations with a plurality of interest groups where governmental reforms are pressuring managers to control costs (Gilbert *et al.*, 2007; Glassman and Winograd, 2004). Consultants have also wondered about slight changes in the conception of the triptych of roles expert-doctor-facilitator. The healthcare organizations where the consultants intervened are professional bureaucracies in which a number of interest groups coexist. This pluralism affects the decision-making process and managers appear reluctant to be held accountable for the consultants' suggestions without the support of other influential actors within the organization.

According to a number of specialists in OD, consultancy practice must incorporate new developments (Burke, 1997; Church *et al.*, 1994; Korten *et al.*, 2010; Leitko and Szczerbacki, 1987; Worley and Feyerhem, 2003) that prompt a rethinking in the practice of OD strictly defined as processual and must combine issues about human resource management as well as strategic issues related to efficiency and productivity. According to Phillips *et al.* (2013), there are ten main pitfalls that explain why OD mandates failed and most of them were found in our own research (see Table VII).

Many of these obstacles may limit the application of OD to contemporary issues faced by the healthcare leaders. Buller (1988) believes that OD's focus traditionally has been on improving organizations' incremental internal processes (planned change) and not sufficiently on a strategic analysis of the external environment. For example, the capacity of an organization to face major reforms related to mergers and costs reduction has not been sufficiently integrated in the OD field. In this respect, a number of authors (Buller; 1988; Jelinek and Litterer, 1988) observe that practitioners and researchers interested in OD must expand their bases of knowledge in relation to strategic analysis of organizations if they wish to be relevant today.

Now, all of the issues in the management of the healthcare sector today, knowing how to manage under pressure and in an uncertain and turbulent context, adjusting to functioning in networks, and learning to innovate , are recurrent themes in strategic management, and, furthermore, particularly relevant in twenty-first century organizations. Nevertheless, many authors reveal adopting new perspectives is not painless and tends to widen the gap between traditionalists, attached to the foundations of the OD field of study and its humanist philosophy, and pragmatists who hope for a renewal of the OD field and a reconciliation between the development objectives of the people concerned and the imperatives of performance and productivity. To make a real and significant contribution to the management of the healthcare organizations, a number of authors believe that OD practitioners and researchers must move beyond this debate and propose new models of intervention to managers, without which

Obstacles (research)	Obstacles (Phillips *et al.*, 2013)
Short term vision of complex situations	Lack of business alignment
Assignments expressed in terms of means instead of strategic objectives to attain	
Demand for quick fix solutions	Not setting the stage for change management
Narrow focus on low cost investment	
Personal agendas that interfere with the efforts of change particularly front-line supervisors and staff	Not including the right people
	Lack of management support
Ill-defined objectives	Failure to identify behavior and impact objectives
	Not using data routinely for process improvement
Focus on solving problems without a grounded diagnosis of the situation	Not conducting comprehensive diagnosis
Focus on rationality with minor considerations for the emotionality of the situation	Organizational culture is not understood
Confusion about what is really expected from the consultant in terms of roles	Not isolating the effects of the intervention
Lack of clarity on mutual responsibilities while the process was underway	Not building data collection into the process

Table VII.
Synthesis of obstacles and levers in achieving the facilitator role defined by Schein

they will remain isolated. If this is true, it could lead consultants to marry and mix different roles, in a more hybrid way, in their interventions to better meet expectations of leaders and managers, particularly in a context of strategic change in the public healthcare sector.

Notes

1. In 2010, 70 percent of funds spent for healthcare originated from public funds.
2. The choice of this firm is based on recommendations made by formal representatives of the Quebec Ministry of Health and Social Services who identified five firms corresponding to the research requirements (geographic proximity, official OD's philosophy statement, experience and expertise mainly in healthcare sector, availability to work with the researcher, access to significant and rich material). One of these five firms accepted to participate in the present research.
3. These 13 cases have been selected as a result of an intra-site (or within case) sampling on the basis of the criteria specified in the text (Miles and Huberman, 1994; Yin, 2009).
4. In the 13 mandates, contractual arrangements encompass the following aspects: a description of the problem, duration of the intervention, presentation of the different steps during the process of intervention, roles and responsibilities of each party throughout the process, content of the reports to be submitted in the course of the mandate, evaluation of the process and the role played by the consultants.

References

Barctecko, S.A. (2010), "The client-consultant relationship: a two-way street", *The Canadian Manager*, Vol. 35 No. 2, pp. 12-13.

Beeby, M., Broussine, M., Grison, L., James, J. and Shutte, A-M. (1999), "Consulting to a 'hurt' or 'upset' organisation", *The Leadership and Organization Development Journal*, Vol. 20 No. 2, pp. 61- 69.

Berry, A. and Oakley, K. (1993), "Consultancies: agents of organizational development. Part I", *Leadership and Organization Development Journal*, Vol. 14 No. 5, pp. 12-20.

Biswas, S. and Twitchell, D. (2002), *Management Consulting. A Complete Guide to the Industry*, Wiley & Sons, New York, NY.

Blake, R.R. and Mouton, J.S. (1983), *Consultation: A Handbook for Individual and Organization Development*, Addison-Westley, Reading, MA.

Block, P. (2011), *Flawless Consulting. A Guide to Getting your Expertise Used*, Jossey-Bass, San Francisco, CA.

Bottin, C. (1991), *Diagnostic et Changement : L'intervention Des Consultants Dans Les Organisations (Diagnosis and Change : The Intervention of Consultants in Organizations)*, Éditions d'Organisation, Paris.

Brown, D.R. (2011), *An Experiential Approach to Organization Development*, Prentice Hall, Upper Saddle, NJ.

Buller, P.F. (1988), "For successful strategic change: blend OD practices with strategic management", *Organizational Dynamics*, Vol. 16 No. 5, pp. 42-55.

Buono, A.F., Nurick, A.J. and Hoffman, A.N. (1995), "Management consulting in the schools: lessons from a system-wide intervention", *Journal of Organizational Change Management*, Vol. 8 No. 3, pp. 18-30.

Burke, W.W. (1997), "The new agenda for organization development", *Organizational Dynamics*, Vol. 26 No. 1, pp. 7-20.

Canadian Association of Management Consultants (CAMC) (2005), "Management Consulting in Canada", Summary Report, prepared by Kennedy Information Inc. for the Canadian Association of Management Consultants, Toronto.

Carter, C. and Crowther, D. (2000), "Organizational consumerism: the appropriation of packaged managerial knowledge", *Management Decision*, Vol. 38 No. 9, pp. 626-637.

Chapman, J. (1998), "Do process consultants need different skills when working with nonprofits", *Leadership and Organization Development Journal*, Vol. 19 No. 4, pp. 211-215.

Church, A.H., Burke, W.W. and Van Eynde, D.F. (1994), "Values, motives and interventions of organization development practitioners", *Group & Organization Management*, Vol. 19 No. 1, pp. 5-50.

Cobb, A. (1986), "Political diagnosis: applications in organizational development", *Academy of Management Review*, Vol. 11 No. 3, pp. 482-496.

Creswell, J.W. (2007), *Qualitative Inquiry & Research Design: Choosing Among Five Approaches*, 2nd ed., Sage Publications, Thousand Oaks, CA.

Cummings, T. and Worley, C.G. (2008), *Organization Development and Change*, 9th ed., South-Western Cengage Learning, Mason, OH.

Davenport, J. and Early, J. (2010), "The power-influence dynamics in a consultant/client relationship", *Journal of Financial Service Professionals*, Vol. 64 No. 1, pp. 72-75.

Denis, J.-L., Dompierre, G., Langley, A. and Rouleau, L. (2011), "Escalating indecision: between reification and strategic ambiguity", *Organization Science*, Vol. 22 No. 1, pp. 225-244.

Denis, J-L., Lamothe, L., Langley, A., Breton, M., Gervais, J., Trottier, L-H., Contacdriopoulos, D. and Dubois, C-A. (2009), "The reciprocal dynamics of organizing and sense-making in the implementation of major public-sector reforms", *Canadian Public Administration*, Vol. 52 No. 2, pp. 225-248.

Devinney, T. and Nikolova, N. (2004), "The client-consultant interaction in professional business services firms: outline of the interpretive model and implications for consulting", draft version presented at The University of New South Wales, New South Wales.

Eisenhardt, K.M. (1989), "Agency theory: an assessment and review", *Academy of Management Review*, Vol. 14 No. 1, pp. 57-74.

Etzioni, A. (Ed.) (1969), *The Semi-Professions and Their Organization*, The Free Press, New York, NY.

Fincham, R. (1999), "The consultant-client relationship: critical perspectives on the management of organizational change", *Journal of Management Studies*, Vol. 36 No. 3, pp. 335-351.

Flyvbjerg, B. (2006), "Five misunderstandings about case-study research", *Qualitative Inquiry*, Vol. 12 No. 2, pp. 219-245.

Fong, E.A. and Tosi, H.L. (2007), "Effort, performance and conscientiousness: an agency theory perspective", *Journal of Management*, Vol. 33 No. 2, pp. 161-179.

Forget, E. (2002), "National identity and the challenge of health reform in Canada", *Review of Social Economy*, Vol. 60 No. 3, pp. 359-375.

French, W.L. and Bell, C.H. (1999), *Organization Development: Behavioral Science Interventions for Organization Improvement*, Prentice-Hall, Englewood Cliffs, NJ.

Furusten, S. and Werr, A. (2005), *Dealing with Confidence. The Construction of Need and Trust in Management Advisory Services*, Copenhagen Business School Press, Copenhagen.

Gilbert, F., Brault, I., Breton, M. and Denis, J.-L. (2007), "Le pilotage des réformes", in Fleury, M.-J., Tremblay, M., Nguyen, H. and Bordeleau, L. (Eds), *Le Système Socio-Sanitaire au Québec*, Gaétan Morin, Montréal, pp. 39-49.

Gill, J. and Whittle, S. (1992), "Management by panacea: accounting for transience", *Journal of Management Studies*, Vol. 30 No. 2, pp. 281-295.

Glassman, A.M. and Winograd, M.A. (2004), "Public sector consultation", in Greiner, L. and Poulfelt, F. (Eds), *Handbook of Management Consulting. The Contemporary Consultant. Insights from World Experts*, Thompson South-Western, pp. 189-210.

Glücker, J. and Ambrüster, T. (2003), "Bridging uncertainty in management consulting: the mechanisms of trust and networked reputation", *Organization Studies*, Vol. 24 No. 2, pp. 269-297.

Golembiewski, R.T. (1989), *Organization Development Ideas and Issues*, Transaction Publishers, New Brunswick, New Jersey.

Golembiewski, R.T., Proehl, C.W. Jr and Sink, D. (1982), "Estimating the success of OD applications", *Training and Development Journal*, Vol. 72 No. 10, pp. 86-95.

Greiner, L.E. and Metzger, R.O. (1983), *Consulting to Management*, Prentice-Hall, Englewood Cliffs, NJ.

Hatch, M. (2012), *Organization Theory. Modern Symbolic and Postmodern Perspectives*, Oxford University Press, Oxford.

Health Canada (2011), "Canada's health care system", available at: www.hc-sc.gc.ca/hcs-sss/pubs/system-regime/2011-hcs-sss/index-eng.php (accessed July 25, 2013).

Hendry, J. (2002), "The principal's other problems: honest incompetence and the specification of objectives", *Academy of Management Review*, Vol. 27 No. 1, pp. 98-113.

Hirsch, P.M., Friedman, R. and Koza, M.P. (1990), "Collaboration or paradigm shift?: Caveat emptor and the risk of romane with economic models for stategy and policy research", *Organization Science*, Vol. 1 No. 1, pp. 87-97.

Jelinek, M. and Litterer, J.A. (1988), "Why OD must become strategic", *Research in Organizational Change and Development*, Vol. 2 No. 1, pp. 135-162.

Jensen, M. and Meckling, W. (1976), "Theory of the firm: managerial behavior, agency costs, and ownership structure", *Journal of Financial Economics*, Vol. 3 No. 4, pp. 305-360.

Kitay, J. and Wright, C. (2004), "Take the money and run? Organisational boundaries and consultants' roles", *The Services Industries Journal*, Vol. 24 No. 3, pp. 1-18.

Korten, F., De Caluwé, L. and Geurts, J. (2010), "The future of organization development : a Delphi study among Dutch experts", *Journal of Change Management*, Vol. 10 No. 4, pp. 393-405.

Kubr, M. (2002), *Management Consulting: a Guide to the Profession*, International Labour Office, Geneva.

Lalonde, C. (2011), "Challenging some universal success criteria in management consulting: when practices meet prescriptions", in Buono, A., Grossmann, R., Lobnig, H. and Mayer, K. (Eds), *Changing Paradigm of Consulting: Adjusting to the Fast-Paced World*, Research in Management Consulting Series, Information Age Publishing, Charlotte, North Carolina, pp. 279-307.

Lalonde, C. (2014), "Revisiting the claim for professionalism. The case of management consultants in the healthcare sector", *Review of Business Research*, Vol. 14 No. 3, pp. 51-74.

Lapsley, I. and Oldfield, R. (2001), "Transforming the public sector: management consultants as agents of change", *The European Accounting Review*, Vol. 10 No. 3, pp. 523-543.

Leitko, T.A. and Szczerbacki, D. (1987), "Why traditional OD strategies fail in professional bureaucracies", *Organization Dynamics*, Vol. 15 No. 3, pp. 52-65.

Lescarbeau, R., Payette, M. and St-Arnaud, Y. (2003), *Profession: Consultant*, Gaétan Morin, Montréal.

Lippitt, G. and Lippitt, R. (1978), *The Consulting Process in Action*, La Jolla University Associates, La Jolla, CA.

Livingston, M. (1998), "Update on health care in Canada: what's right, what's wrong, what's left", *Journal of Public Health Policy*, Vol. 19 No. 3, pp. 267-288.

Lundberg, C.C. and Young, C.A. (2001), "A note on emotions and consultancy", *Journal of Organizational Change Management*, Vol. 14 No. 6, pp. 530-538.

McKinney-Kellogg, D. (1984), "Contrasting successful and unsuccessful OD consultation relationships", *Group & Organization Studies*, Vol. 9 No. 2, pp. 151-176.

McLachlin, R. (1999), "Factors for consulting engagement success", *Management Decision*, Vol. 37 No. 5, pp. 394-402.

Martin, J.F. (2000), "Policy consulting and public policy", *Australian Journal of Public Administration*, Vol. 59 No. 1, pp. 24-35.

Miles, M.B. and Huberman, A.M. (1994), *Qualitative Data Analysis: An Expanded Sourcebook*, Sage Publications, Thousand Oaks, CA.

Miller, E. (1995), "Dialogue with the client system: use of the 'working' note in organizational consultancy", *Journal of Managerial Psychology*, Vol. 10 No. 6, pp. 27-30.

Mitchell, R.G. (1993), *Secrecy and Fieldwork*, Sage Publications, Newbury Park, CA.

Mohe, M. and Seidl, D. (2011), "Theorizing the client-consultant relationship from the perspective of social-systems theory", *Organization*, Vol. 18 No. 1, pp. 3-22.

Mukherji, A., Wright, P. and Mukherji, J. (2007), "Cohesiveness and goals in agency networks: explaining conflict and cooperation", *The Journal of Socio-Economics*, Vol. 36 No. 1, pp. 949-964.

Nikolova, N. and Devinney, T.M. (2009), "Influence and power dynamics in client-consultant teams", *Journal of Strategy and Management*, Vol. 2 No. 1, pp. 31-55.

Numa, G. (2009), "Théorie de l'agence et concessions de chemins de fer français au 19ème siècle" (Agency Theory and French Railways Concessions in the 19th Century), *Revue D'économie Industrielle*, Vol. 1 No. 125, pp. 105-128.

Palley, H.A. and Forest, P.-G. (2004), "Canadian fiscal federalism, regionalization, and the development of Quebec's health care delivery system", *New Global Development*, Vol. 20 No. 2, pp. 87-96.

Pellegrinelli, S. (2002), "Managing the interplay and tensions of consulting interventions. The consultant-client relationship as mediation and reconciliation", *Journal of Management Development*, Vol. 21 Nos 5/6, pp. 343-365.

Pepper, A. and Gore, J. (2014), "The economic psychology of incentives", *An International Study of Top Managers*, Vol. 49 No. 3, pp. 350-361.

Perrow, C. (1986), *Complex Organizations*, Random House, New York, NY.

Pettigrew, A. (1987), "Context and action in the transformation of the firm", *Journal of Management Studies*, Vol. 24 No. 6, pp. 649-670.

Phillips, P.P., Phillips, J.J. and Zuniga, L. (2013), *Measuring the Success of Organization Development. A Step-by-step Guide for Measuring Impact and Calculating ROI*, ROI Institute, Alexandria, VA.

Phillips, R. and Bosse, D. (2013), "Agency theory and bounded self interest: the moderating role of fairness", available at: http://works.bepress.com/robert_phillips/1 (accessed July 25, 2013).

Pineault, R., Lamarche, P., Champagne, F. and Contandriopoulos, A.-P. (1993), "The reform of the Quebec health care system : potential for innovation?", *Journal of Public Health Policy*, Vol. 14 No. 2, pp. 198-219.

Poulfelt, F. and Greiner, L. (2004), "Research on management consulting", in Greiner L. and Poulfelt, F. (Eds), *Handbook of Management Consulting. The Contemporary Consultant. Insights from World Experts*, Thompson South-Western, Mason, Ohio, pp. 345-358.

Quinn, R.E. and Quinn, S.E. (2004), "On becoming a transformational change agent", in Greiner, L. and Poulfelt, F. (Eds), *Handbook of Management Consulting. The Contemporary Consultant. Insights from World Experts*, Thompson South-Western, Mason, Ohio, pp. 251-268.

Ross, S. (1973), "The economic theory of agency: the principal's problem", *American Economic Review*, Vol. 63 No. 2, pp. 134-139.

Sappington, D.E. (1991), "Incentives in principal-agent relationships", *Journal of Economics Perspectives*, Vol. 5 No. 2, pp. 45-66.

Schaffer, R.H. (2002), *High-Impact Consulting. How Clients and Consultants Can Work Together to Achieve Extraordinary Results*, Jossey-Bass, San Francisco, CA.

Schein, E.H. (1969), *Process Consultation. Its Role in Organization Development*, Addison-Wesley, Reading, MA.

Schein, E.H. (1987), *Process Consultation. Lessons for Managers and Consultants*, Addison-Wesley, Reading, MA.

Schein, E.H. (1995), "Process consultation, action research and clinical inquiry: are they the same?", *Journal of Managerial Psychology*, Vol. 10 No. 6, pp. 14-19.

Schein, E.H. (1997), "The concept of 'client' from a process consultation perspective. A guide for change agents", *Journal of Organizational Change Management*, Vol. 10 No. 3, pp. 202-216.

Schein, E.H. (1999), *Process Consultation Revisited. Building the Helping Relationship*, Addison-Wesley, Reading, MA.

Schein, E.H. (2009), *Helping. How to Offer, Give, and Receive Help*, Berret-Koehler, San Francisco, CA.

Schön, D.A. (1983), *The Reflective Practitioner*, Basic Books, New York, NY.

Shapiro, E.C., Eccles, R.G. and Soske T.L. (1993), "Consulting: has the solution become part of the problem?", *Sloan Management Review*, Vol. 34 No. 4, pp. 89-95.

Shapiro, S.P. (2005), "Agency theory", *Annual Review of Sociology*, Vol. 31 No. 1, pp. 263-284.

Sharma, A. (1997), "Professional as agent: knowledge asymmetry in agency exchange", *Academy of Management Review*, Vol. 22 No. 3, pp. 758-798.

Shea, G. and Berg, D. (1987), "Analysing the development of an OD practitioner", *The Journal of Applied Behavioral Science*, Vol. 23 No. 3, pp. 315-336.

Simon, A. and Kumar, V. (2001), "Clients' views on strategic capabilities which lead to management consulting success", *Management Decision*, Vol. 39 No. 5, pp. 362-372.

Smith, J.A., Flowers, P. and Larkin, M. (2009), *Interpretative Phenomenological Analysis. Theory, Method and Research*, Sage Publications, London.

Smith, M.E. (2002), "What client employees say about consultants", *Leadership and Organization Development Journal*, Vol. 23 No. 2, pp. 93-103.

St-Martin, D. (1998), "The new managerialism and the policy of consultants in government: an historical-institutional analysis of Britain, Canada and France", *Governance: An International Journal of Policy and Administration*, Vol. 11 No. 3, pp. 319-356.

Stumpf, S.A. and Longman, R.A. (2000), "The ultimate consultant: building long-term, exceptional value client relationships" *Career Development International*, Vol. 5 No. 3, pp. 124-134.

Sturdy, A. (1997), "The consultancy process – an insecure business", *Journal of Management Studies*, Vol. 34 No. 3, pp. 389-413.

Sturdy, A. (2011), "Consultancy's consequences? A critical assessment of management consultancy's impact on management", *British Journal of Management*, Vol. 22 No. 3, pp. 517-530.

Suddaby, R. and Greenwood, R. (2001), "Colonizing knowledge, commodification as a dynamic of jurisdictional expansion in professional service firms", *Human Relations*, Vol. 54 No. 7, pp. 933-953.

Ulvila, J.W. (2000), "Building relationships between consultants and clients", *American Behavior Scientist*, Vol. 43 No. 10, pp. 1667-1680.

Verstraeten, M. (2007), *Consultants en Organisation. Stratégies et Pratiques De L'intervention (Consultants in Organizations. Strategies and Practices of Intervention)*, De Boeck, Brussels.

Waterman, R.W. and Meier, K.J. (1998), "Principal-agent models: an expansion?", *Journal of Public Administration Research and Theory*, Vol. 8 No. 2, pp. 173-202.

Werr, A. and Styhre, A. (2003), "Management consultants – friend or foe?", *International Studies of Management & Organization*, Vol. 32 No. 4, pp. 43-66.

Whittle, A. (2006), "The paradoxical repertoires of management consultancy", *Journal of Organizational Change Management*, Vol. 19 No. 4, pp. 424-436.

Williams, R. (2004), "Management fashions and fads. Understanding the role of consultants and managers in the evolution of ideas", *Management Decision*, Vol. 42 No. 6, pp. 769-780.

Worley, C.G. and Feyerhem, A.E. (2003), "Reflections on the future of organization development", *Journal of Applied Behavioral Science*, Vol. 39 No. 1, pp. 97-115.

Wright, P., Mukherji, A. and Kroll, M.J. (2001), "A reexamination of agency theory assumptions: extensions and extrapolations", *Journal of Socio-Economics*, Vol. 30 No. 5, pp. 413-429.

Yin, R.K. (2009), *Case Study Research. Design and Methods*, 4th ed., Sage Publications, Thousand Oaks, CA.

Appendix 1

Sub-cases	Transformation context	Nature of mandate	Goals pursued	Duration/year of completion
1	Merger	Evaluate impacts of organizational changes following merger	Check to see if integration goals related to new organizational structure are attained and make recommendations to general management to improve integration	18 months/2005
2	Reform (at level) of missions	Develop an organization model for welcoming services in view of new staff transfers	Propose organization model for the welcoming service that can settle interdepartmental conflict situation	6 months/2005
3	Merger	Participate in developing new organization plan made necessary by merger	Adapt organization structure and framework to new reality	12 months/2005
4	Merger	Participate in developing new organization plan made necessary by merger	Adapt organization structure and framework to new reality	12 months/2006
5	Reform (at level) of missions	Propose mechanisms for professional supervision and monitoring of psychosocial staff in view of new staff transfers	Harmonize professional practices and make them more efficient; develop a common organizational culture	8 months/2006
6	Reform (at level) of missions	Develop programming for psychosocial services, taking into account new departmental orientations and new staff transfers	Respond to complaints expressed by staff about supervision and monitoring mechanisms that fall short of expectations	15 months/2006
7	Reform (at level) of missions	Develop proposition for updating range of services offered by organization, taking into account new departmental orientations	Compress current service offer to take into account departmental and regional priorities and budgetary reality	7 months/2007
8	Revision of an inter-organizational regrouping model	Propose a performance model for mental health team	Improve climate within this team and re-examine nature of partnership around this mandate at grantor's request	8 months/2007
9	Reform of missions	Participate in harmonization strategy for youth services, taking	Adjust service offer according to new departmental and	14 months/2007

(*continued*)

Table AI. Description of transformation context, nature of mandates entrusted to consultant, goals pursued and duration

Sub-cases	Transformation context	Nature of mandate	Goals pursued	Duration/year of completion
		into account new departmental orientations	regional priorities and make it more efficient	
10	Merger	Participate in developing new organization plan made necessary by merger	Adapt organization structure and framework to new reality	11 months/2008
11	Reform of missions	Propose a reorganization plan for physical work spaces in view of new staff transfers	Find a fair and just solution likely to satisfy demands of the various professional groups and departments involved	6 months/2008
12	Merger	Develop and offer a training program for new executives following a merger context	Develop basic management skills with new executives and bring executives to integrate philosophy of the general management in terms of integration between the two missions (psychosocial and rehabilitation)	6 months/2008
13	Reform (at level) of missions	Evaluate service offer in rehabilitation for clients followed up at home for a more efficient management of demand for these services	Propose solutions to reduce waiting list in view of new departmental orientations	6 months/2008

Table AI.

Appendix 2. Matrix of classification

Sub-cases	Content analysis of the business contracts	Observations recorded in professional logs	Content analysis of a variety of materials	Group interviews with the associated senior consultants
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				

Table AII.
Step 1: Identify the relevant material for each sub-case

Sub-cases	Entry Phase	Diagnosis Phase	Implementation Phase	Concluding Phase
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				

Table AIII.
Step 2: Classify the relevant material for each sub-case and for each phase

	Rater 1		Rater 2	
	Who is involved?	How?	Who is involved?	How?
Entry phase	Nature of the initial contact/quality of the informant(s)		Nature of the initial contact/quality of the informant(s)	
	Introduction of the consultant in the organization/nature and quality of the communication with the client-system		Introduction of the consultant in the organization/nature and quality of the communication with the client-system	
Diagnosis phase	Level of responsibility of the manager assigned to follow the process		Level of responsibility of the manager assigned to follow the process	
		Type of diagnosis needed (content, scope, data to be collected)		Type of diagnosis needed (content, scope, data to be collected)
Implementation phase	Level of responsibility of the manager assigned to follow the process		Level of responsibility of the manager assigned to follow the process	
	Issues raised by members of organization during the process		Issues raised by members of organization during the process	
Concluding phase	Evaluation of the interventions performed by consultants		Evaluation of the interventions performed by consultants	
	Consultant assured a follow-up		Consultant assured a follow-up	

Table AIV.
Step 3: Synthetize the specific information from relevant material for each phase

Appendix 3

Table AV.
Roles requested, roles played, roles required by consultant based on Schein's triptych: doctor, expert or facilitator[a]

Sub-cases	Role triptych: Role requested (at beginning)	Role played (during)	Role required (after)	Observations by consultant as recommendations to top management
1	Expert	Expert	Expert/ facilitator	Leaders must pay attention to their management style
2	Doctor	Doctor/ expert	Expert/ facilitator	Top management must hold a work session with its executives and become more involved in finding solutions
3	Facilitator	Facilitator	Facilitator	Frustration among some executives because top management did not keep promises of promotion
4	Expert	Expert	Expert/ facilitator	Top management must hold a work session with its executives, involving them more in the implementation of a new organizational structure
5	Doctor	Doctor/ expert	Expert/ facilitator	Executive responsible for unit targeted by the mandate must play a more active role
6	Doctor	Doctor/ expert	Facilitator	Executive responsible for unit targeted by the mandate must play a more active role
7	Doctor	Doctor/ expert	Facilitator	All executives must become more involved and develop consistency in action
8	Doctor	Doctor/ expert	Expert/ facilitator	Managers must make decisions and stop procrastinating
9	Facilitator	Expert/ facilitator	Facilitator	The committee of partners must specify needs in support and assistance and clarify lines of authority for managing the project
10	Facilitator	Facilitator	Facilitator	Top management must hold a work session with its executives, involving them more in the implementation of a new organizational structure
11	Expert	Expert/ facilitator	Facilitator	A decision must be made for implementing the solution
12	Expert	Expert	Expert/ facilitator	Top management was overtaken by the human resources branch, and the strategic part of the mandate was not carried out
13	Doctor	Doctor/ expert	Facilitator or expert, as needed	Top management must implement the solution chosen with the agreement of the staff concerned

Notes: [a]The interventions under each role have been classified using the matrix proposed by Kubr (2002, p. 74) and the typology of interventions initially developed by Friedlander and Brown (1974) and updated by Cummings and Worley (2008) and Brown (2011). For instance, interventions related to human process and human resource development were more likely to be classified under the facilitator role; interventions related to the technostructure were more likely to be classified under the expert role; and, interventions related to strategic analysis were more likely to be classified under the doctor role

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